STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 946123
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

VOLUNTARY DIRECTIVE FOR ALTERNATE SERVICE OF MEDICAL-LEGAL EVALUATION REPORT ON DISPUTED INJURY TO PSYCHE
(Unrepresented Employees Only)

Injured Employee Name: _____

Date of Injury: _____

Claim No.: _____

WCAB Case No.: _____

Claims Administrator: _____

Name of QME: _____

Date of Evaluation Exam: _____

I, _____,
(print name of injured employee)

understand I have a right to be served with a copy of the medical-legal evaluation report ~~to be~~ written about my case by the QME physician named above, at the same time as a copy of the report is sent to the claims administrator and*/or* the Disability Evaluation Unit.

By signing below, I hereby direct that the QME serve my copy of the medical/legal report in the following manner:

(Check one)

☐ **By ~~sending a copy to me at my address on file AND~~ sending ~~a~~ *my* copy to the following physician who will review it with me and will be paid for an office visit for this purpose by *~~the claims administrator, or if none by~~* my employer. *The physician I name below can be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician named below will give me my copy of the report*:**

Physician Name: _____

Address: _____

City: _____ **Zip:** _____

Phone: _____

☐ **Only by sending a copy to me at my address on file. *I do not wish to ~~have~~ designate a physician to review it with me.***

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I am signing this directive voluntarily and of my own free will:

(Signature of Injured Employee)	*Date*

Original of this signed form – attach to original medical-legal report
Copies of this signed form – to injured employee, claims administrator, reviewing physician, QME